DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 0

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
BIPA 3 702

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19B, Item 2b, Pages 1-2:
Item 2C, Pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19B, Item 2b, Pages 1-2
Item 2C, Pages 1-2

10. SUBJECT OF AMENDMENT:
PPS for RHCs and FQHC

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert J. Seiffert

13. TYPED NAME:
Robert J. Seiffert

14. TITLE:
Medicaid Administrator

15. DATE SUBMITTED:
7/16/01

16. RETURN TO:
HHS, F&S
Medicaid Division
Attn: Bob Seiffert
P.O. Box 95026
Lincoln, NE 68509-5026

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
07/18/01

18. DATE APPROVED:
AUG 22 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting ARA for Medicaid & State Operations

23. REMARKS:

cc:
Curtiss
Seiffert
CO

SPA CONTROL
Date Submitted: 07/16/01
Date Received: 07/18/01

FORM HCFA-179 (07-92)

Instructions on Back

Substitute per letter dated 8/21/01

ATTACHMENT 4.19-B
Item 2b, Page 1 of 4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

__X__ The payment methodology for RHCs will conform to Section 702 of the BIPA 2000 legislation. (All States should check this one.)

_____ The payment methodology for RHCs will conform to the BIPA 2000 requirements Prospective Payment System.

__X__ The payment methodology for RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology will:

1) be agreed to by the State and the center or clinic in a written memorandum form; and
2) will result in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

RURAL HEALTH CLINICS

A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with departments of the facility.

PROSPECTIVE PAYMENT SYSTEM (PPS)

Effective January 1, 2001, the Prospective Payment System (PPS) base rate will be computed as follows:

1. Combine reasonable costs from the RHC center/clinic fiscal year 1999 and 2000 cost reports.
2. Divide the costs by the combined Total Adjusted Visits from the two fiscal year cost reports (Form HCFA – 222-92 Worksheet C, Part 1, Line 6; or Form HCFA – 2552-96 Worksheet M-3, Line 6).

This PPS base rate will be the center's final rate for January 1, 2001 through September 30, 2001. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

Substitute per letter dated 8/21/01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

ALTERNATIVE PAYMENT METHODOLOGY (APM)

For the rate period January 1, 2001, through September 30, 2001 centers/clinics may choose to have their rate computed under the Alternative Payment Methodology. To choose this method, the center/clinic must make this selection on the written memorandum form provided by the Department.

Under the Alternative Payment Method, the rate for Rural Health Clinic (RHC) services provided by provider-based RHCs associated with hospitals of 50 beds or less is the lower of cost or charges, as established by Medicare. Rates for the provider-based RHC centers/clinics associated with hospitals of 50 beds or more and Independent Rural Health Clinics are computed at the all inclusive encounter rate established by Medicare. The center/clinic's final rate for January 1, 2001 through September 30, 2001, is the greater of the APM rate or the PPS base rate. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to Nebraska Medicaid practitioners fee schedule.

RATES FOR NEW RHC CENTERS/CLINICS

Effective January 1, 2001, initial interim rates for new RHCs entering the program after 1999, will be the average PPS rate of all RHC clinic/centers in Nebraska. The RHC's individual PPS base rate will be computed later, using its initial cost report. Once the PPS base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI). The interim rate will be retroactively settled based on the RHC clinic/center's initial cost report.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

RHC MANAGED CARE PAYMENT

RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly State supplemental payments for the cost of furnishing such services, the difference between the payment the RHC receives from MCE(s) and the payments the RHC would have received under the alternative methodology. At the end of each RHC fiscal year, the total amount of supplemental and MCE payments received by the RHC will be reviewed against the amount that the actual number of visits provided under the RHCs contract with MCE(s) would have yielded under the alternative methodology. The RHC will be paid the difference between the amount calculated using the alternative methodology and the actual number of visits, and the total amount of the supplemental and MCE payments received by the RHC, if the alternative amount exceeds the total amount of supplemental and MCE payments. The RHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the RHC if the alternative method is less than the total amount of the supplemental and MCE payments.

Reimbursement for radiology services is included in the encounter rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

It is the responsibility of the centers/clinics to inform and supply the State of Nebraska with necessary documentation regarding changes to types of service, cost reports and any other documentation.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service. RHC core services provided via telehealth technologies are not covered under the encounter rate. See Attachment 3.1A, Item 2b.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

__X__ The payment methodology for FQHCs will conform to Section 702 of the BIPA 2000 legislation. (All States should check this one.)

_____ The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

__X__ The payment methodology for FQHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology will:

1) be agreed to by the State and the center or clinic; and
2) will results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

FEDERALLY-QUALIFIED HEALTH CENTERS

PROSPECTIVE PAYMENT SYSTEM (PPS)

Effective January 1, 2001, the Prospective Payment System (PPS) base rate will be computed as follows:

1. Combine reasonable costs from the FQHC center/clinic fiscal year 1999 and 2000 cost reports.
2. Divide the costs by the combined Total Adjusted Visits from the two fiscal year cost reports (Form HCFA – 222-92 Worksheet C, Part 1, Line 6; or Form HCFA – 2552-96 Worksheet M-3, Line 6).

This PPS base rate will be the center's final rate for January 1, 2001 through September 30, 2001. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

ALTERNATIVE PAYMENT METHODOLOGY (APM)

For the rate period January 1, 2001, through September 30, 2001 centers/clinics may choose to have their rate computed under the Alternative Payment Methodology. To choose this method, the FQHC center/clinic must make this selection on the written memorandum form provided by the Department.

The Nebraska Medical Assistance Program (NMAP) makes payment for services provided by federally-qualified health centers (FQHCs) as defined in section 1905(a)(2)(C) of the Social Security Act on the basis of 100 percent of reasonable costs attributed to the care of Medicaid-eligible clients, as established by the Nebraska Department of Health and Human Services Finance and Support.

Reasonable costs are determined by the Department on the basis of the FQHCs cost report, submitted as the Medicare cost report (Form HCFA-222). Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Providers participating in the NMAP as FQHCs must submit to the Department a plan for allocating costs to the Medicaid program. This plan must also indicate the annual cost reporting period by which the FQHC plans to report its annual costs to the Department.

For those non-FQHC services for which no charge has been established by Medicare, NMAP makes payment according to Nebraska Medicaid practitioners fee schedule.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

RATES FOR NEW FQHC CENTERS/CLINICS

Effective January 1, 2001, initial interim rates for new FQHCs entering the program after 1999, will be the average PPS rate of all FQHC clinic/centers in Nebraska. The FQHC's individual PPS base rate will be computed later, using its initial cost report. Once the PPS base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI). The interim rate will be retroactively settled based on the FQHC center/clinic initial cost report.

FQHC MANAGED CARE PAYMENT

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payment the FQHC receives from MCE(s) and the payments the FQHC would have received under the alternative methodology. At the end of each FQHC fiscal year, the total amount of supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHCs contract with MCE(s) would have yielded under the alternative methodology. The FQHC will be paid the difference between the amount calculated using the alternative methodology and the actual number of visits, and the total amount of the supplemental and MCE payments received by the FQHC, if the alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC if the alternative method is less than the total amount of the supplemental and MCE payments.

Substitute per letter dated 8/21/01"

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